# Cognitive screening of older patients

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## Clinical question

**Who should I assess for cognitive impairment and what screening tools should I use?**

## Bottom line

The Canadian Task Force on Preventive Health Care

> *recommend[s] not screening asymptomatic adults 65 years of age or older for cognitive impairment. (Strong recommendation, low-quality evidence) ....* The recommendation does not apply to [patients with] symptoms suggestive of cognitive impairment ... or who are suspected of having cognitive impairment by clinicians, family or friends.[1]

But if family and friends do not report cognitive impairment (because they do not notice it or incorrectly label it "normal aging"), what signs should alert clinicians to its subtler forms? Once suspected, what screening tools should clinicians employ? This is especially pertinent given changes in access to the Montreal Cognitive Assessment (MoCA).

The Mini-Mental State Examination used to be most commonly used until the rights owners began to charge for use. Many FPs then began using MoCA. Recently, one of the MoCA developers announced he will be charging for training, certification, and access to the full website resources. What other tools have been validated in primary care?

## Evidence

Six reasonably brief cognitive screening tests have been validated in primary care: Mini-Cog, Memory Impairment Screen, General Practitioner Assessment of Cognition, Short Portable Mental Status Questionnaire, Free and Cued Selective Reminding Test, and 6 Item Cognitive Impairment Test.[2-9] To learn more visit **www.dementiascreen.ca**.

## Approach

Patients do not always come to you with cognitive concerns (in fact, patients might lose awareness of their impairment). Some caregivers incorrectly dismiss cognitive changes as "normal aging" and do not raise the issue. Paying attention to subtler signs (**Box 1**) might flag those needing screening.

When patients or families raise concerns, do not assume it is normal aging; always consider formal assessment. Guidelines can help guide the overall approach to initial assessment (**www.cfp.ca/content/60/5/433**), which should include cognitive screening, medication review, and investigations for remediable factors.[10]

**Box 1.** Behavioural flags suggestive of dementia

- Frequent calls to the office or visits to the doctor or emergency department
- Poor historian, vague, seems "off," repetitive
- New nonadherence with medications or instructions (loss of ability to manage concurrent medical conditions that they could manage in the past)
- Changes in appearance, mood, personality, behaviour
- Word-finding problems, decreased social interaction
- Missing appointments, coming on the wrong day
- Confusion: postoperative delirium or with illness or new medications
- Weight loss in the older person living alone
- Driving: accidents, problems, tickets, family concerns
- Head-turning sign (turning to caregiver for answers)

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## Implementation

Use a screening tool in addition to reviewing functional effects of deficits, with corroboration from family if possible. No cutoff score on any test definitively diagnoses dementia; your knowledge of the patient and their function is key. Screening score is relevant but one of many factors. How the patient approaches tasks—which they do well; what is challenging—provides useful information particularly compared with past ability. As decline progresses, repeat testing with the same tool might provide objective information.

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**Competing interests**
None declared

**References**

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